HISTORY

OF

BLUE CROSS AND BLUE SHIELD

From: Blue Cross
Blue Shield
Association

INTRODUCTION

Welcome to Blue Cross and Blue Shield of Florida. We are proud to have you as a member of our employee family. We look to each member of our team for the skill to contribute and the potential to grow while helping us to achieve our common goal -- the best possible health care protection and quality service to our subscribers.

To be successful, a company must do more than just maintain its current condition -- it must constantly strive to improve itself. By financial measure, it strives to increase sales and earnings. By customer measure, it strives to provide increasingly better products and service. By public measure, it seeks the support of its publics. And by any measure, a company can achieve success only through the commitment and contributions of its people.

Because we believe that the ultimate success of our organization is directly dependent on people, we recognize that our employees are our most valuable asset. This concept is one of our basic corporate values. Basically, it comes down to treating employees with dignity; establishing a climate of trust, cooperation and employee involvement; and providing an environment for open, timely communication, job satisfaction, financial security and opportunities for growth and accomplishment.

There is a lot to learn about our organization. Most of it you will learn gradually, as you come to work every day. The Corporate Orientation Program and supplemental materials highlight some of the basic information you will need to know as you begin your career with us. It is not intended to alter or replace official policies described in the Human Resource Policies and Procedures Manual or other company documents. The policies and practices summarized herein are subject to change as deemed advisable and/or necessary by management. This information is not to be considered a part of any employment agreement with our employees.

Management personnel throughout Blue Cross and Blue Shield of Florida have been assigned Human Resource Policies and Procedure Manuals that are accessible to all employees. You are encouraged to review these policies and procedures with your immediate manager for clarification.

We are glad you are with us. Thank you for joining our efforts to provide the best possible services to the people of Florida. We hope that your career with us will be a long and rewarding partnership.

WHAT WE'RE ABOUT

OUR MISSION

We recognize that all members of society have a need for access to quality health care at a reasonable cost. The basic purpose of Blue Cross and Blue Shield of Florida is to help meet those needs by providing efficient and effective health care financing, administrative, and delivery services.

HELPING PEOPLE: HOW IT ALL BEGAN

The history of Blue Cross and Blue Shield is a story about Americans helping each other.

The Blue Cross idea began in Dallas, Texas, in 1929. The country was entering the Great Depression and the Baylor University Hospital was experiencing severe financial difficulties. This set the stage for a unique concept in health care. Justin Ford Kimball, the Dallas superintendent of schools, contracted with the hospital to pay $6.00 a year for each Dallas teacher. When a teacher became ill, he or she was hospitalized at Baylor free of charge for 21 days. The idea of pre-paid health care was born.

The Dallas idea lead to similar arrangements throughout the country, each involving a single hospital. By 1932, community-wide pre-payment plans began to emerge, offering subscribers a choice of hospitals. In 1939, more than three million Americans were involved.

The symbol of a blue cross came into being in 1932, when an executive of the St. Paul, Minnesota program started using it on company stationery. Other programs adopted it, and in 1939 it became official. As originally designed, the symbol was in the shape of the Geneva cross -- the international emblem for the relief of the sick and wounded. Superimposed on the cross was a seal of the American Hospital Association. In 1972, the symbol was changed by placing a human figure within the cross to better symbolize our primary focus on the people in the communities we serve.

The prepaid health care idea for hospital expenses was matched in 1939 by a pre-paid plan designed to cover physicians' services. Founded in California as the California Physicians Service, this system evolved from a number of county medical pre-payment bureaus that developed before the turn of the century in the northwestern United States.

Founded as separate organizations from Blue Cross, the physicians' services plans adopted the shield as their symbol because, throughout history, the shield has served to protect the body. Superimposed upon it is the knotty staff with the entwined serpents, known as the caduceus, the symbol of the Greek god of medicine which continues as the symbol of the physician today.

A NATIONWIDE NETWORK

Today, "Blue Cross" and "Blue Shield" are the names and symbols used by 73 independent companies, locally managed and governed, each with its own health care programs, products and policies. These companies, usually referred to as Blue Cross and Blue Shield plans, form a nationwide network or federation of autonomous corporations, each operating under the laws of their particular state. There are 92 "Blue Cross" and "Blue Shield" plans world wide.

Blue Cross programs, created to cover hospital expenses, have expanded their coverage into outpatient care, other institutional services and even home care. Blue Shield plans, established mainly to cover physician services, now provide benefits such as dental, vision and outpatient services.

SERVING 100 MILLION PEOPLE

As a federation of plans, Blue Cross and Blue Shield employ nearly 125,000 people. We serve about 100 million Americans in both the private and public sectors -- almost one of every two persons in this country. As a total entity, Blue Cross and Blue Shield Plans would rank among the largest corporations in the United States. We are larger, by far, than the 10 next largest commercial insurance companies in the country combined.

Each of the Plans works cooperatively with others, participating with one another on national accounts, an insurance program for federal employees, claims services for visiting subscribers from other states, and other efforts.

The Blue Cross and Blue Shield Association in Chicago is the Plans' coordinating agency. It speaks for them in matters of national concern; initiates and coordinates public education programs; contributes to cost containment efforts; and provides research, statistical, actuarial, marketing and other services. It also links the plans with a computerized telecommunication system.

Blue Cross and Blue Shield were formed to help people pay medical bills. Partly as a result of their ability to pay, Americans have had the best health care available anywhere in the world. To maintain this high standard, and keep health care affordable, is the challenge being faced by Blue Cross and Blue Shield.

HISTORY OF THE BLUE CROSS AND BLUE SHIELD ORGANIZATION

"Blue Cross" and "Blue Shield" have become household words in the United States. The familiar symbols are instantly recognized as representing protection from the costs of hospital and medical bills for millions of Americans.

The Blue Cross and Blue Shield organization is not a single company. Rather, it is a nationwide federation of 79 locally governed, autonomous corporations, each operating under state law as a non-profit service organization. (Each local corporation is known as a Plan.)

The pre-payment movement now known as the Blue Cross and Blue Shield organization grew up in local communities, gradually spreading to other communities, joining together at a regional or state level, and eventually forming a national organization to coordinate the activities of the local Plans.

The Blue Cross Plans were founded primarily to cover hospital expenses, though they have expanded their coverage into out-patient care, other institutional services and even home care. The Blue Shield Plans were established primarily to cover physician's services, though they too have expanded into other benefits, such as dental and vision care. In most areas, Blue Cross and Blue Shield Plans cooperate closely and many, a single management. Or they may share office space, conduct joint enrollment and billing functions. In other areas, they are separate organizations which overlap in the benefits they offer, or even compete with each other.

How did this pre-payment movement come about?

The Blue Cross Idea

During the 1920's, hospitals in several states offered their communities a new method of paying for hospital care in advance of need. The most successful of the Plans was at the Baylor University Hospital in Dallas, Texas, under the leadership of Justin Ford Kimball, Ph.D., Executive Vice-president of Baylor University. In 1920, a group of Dallas school teachers worked out an agreement with the University Hospital. For a monthly sum of $.50 per teacher, each was assured of receiving 21 days of care in a semi-private hospital room when needed.

Other groups of employees in the Dallas area joined the group. The Baylor program was described at the annual meeting of the American Hospital Association in 1931. The idea soon attracted nationwide attention and similar arrangements spread throughout the country. The deepening Depression gave impetus to the movement as millions of persons recognized the need to protect themselves from the devastating cost of illness.

At first, each plan involved only an individual hospital, but by 1932, community-wide agreements offering subscribers a choice of hospitals began to emerge. Among the first communities to have programs of this sort were Sacramento, California; Newark, New Jersey; and New York City.

In 1933, E.A. van Steenwyk, first executive of the Hospital Service Association of St. Paul, Minnesota, used a blue cross to identify his program on stationery, folders, and other printed material. The idea caught on, and other programs started using the same symbol. In 1939, the Blue Cross symbol was officially adopted by a commission of the American Hospital Association, which also developed membership standards which the Plans had to meet. Plan dues supported the commission from 1941 on.

In 1960, the Blue Cross Commission was replaced by the Blue Cross Association, which had been operating independently of the AHA since 1948, and was supported by dues from the Blue Cross Plans. In 1972, formal ties with the American Hospital Association were severed.

The design in the center of the Blue Cross symbol was revised in 1972 when the Blue Cross name, service mark, and approval program were transferred from the AHA to the Blue Cross Association. The stylized human figure in the center of the cross symbolizes all mankind and the role of the Plans in serving human needs.

Origins of the Blue Shield Concept

In the lumbering and mining camps of the Pacific Northwest at the turn of the century, employers contracted for medical services for their workers with individual physicians who were paid a monthly fee. That arrangement led to establishing "medical service bureaus" composed of groups of physicians contracting their services to employers. The workers then had the freedom to choose their doctor from among the participating physicians. The first of the county service bureaus in the Northwest was organized in Tacoma, Washington by Pierce County physicians in 1917. Numerous such bureaus were founded and many including the Pierce County bureaus are still in operation today as Blue Shield Plans.

In 1938, the American Medical Association's house of delegates endorsed the principle of voluntary health insurance, a move that encouraged physician cooperation in pre-payment programs. A year later, a Blue Shield Plan was begun in California as California Physicians Service. It provided physician services to employee group members of $1.70 per month and was limited to those earning less than $3,000 per year.

During the next few years, a number of similar Plans were established throughout the country. Although they were not affiliated, they had in common some elements that were to become basic to the Blue Shield movement.

The Blue Shield Plans were sometimes subsidized by physicians. They were founded around a nucleus of participation doctors who agreed to accept payment from the Plans as full payment for services rendered to subscribers. If the Plan ran out of money it would be the doctors who stood the losses. Most of the Plans worked closely with Blue Cross Plans for joint enrollment and fee collection.

The Blue Shield name and symbol were first used by a pre-paid plan in Buffalo, New York, known today as Blue Shield of Western New York. The name and symbol were informally adopted by the Associated Medical Care Plans in 1948, and registered officially in 1951 for Blue Shield Plans.

The need for a national organization was recognized early. Nine of the non-profit pre-payment plans joined together in 1946 to form Associated Medical Care Plans. Other Plans soon joined. Later, the organization became the National Association of Blue Shield Plans and eventually in 1976 the Blue Shield Association.

The two national organizations, consolidated staffs in 1978, and formally merged in 1982 to form the Blue Cross and Blue Shield Association.

Growth of Pre-payment

The health insurance concept was stimulated by the Depression, when millions of Americans found it difficult to meet day-to-day expenses, let alone the costs of an illness or accident. With the introduction of legislation like the 1935 Social Security Act, unemployment compensation, and old age assistance programs, the concept was given additional emphasis. With the onset of World War II, the fringe benefits concept began to develop and take hold within the United States. Employers, unable to raise wages because of the wage freeze laws, began to offer employees fringe benefits in lieu of wage increases. Because of the basic need which health insurance filled for Americans of all economic levels, health coverage was a much sought-after benefit.

The health insurance concept was further stimulated by the experience of returning servicemen. Accustomed to having their medical needs provided by the military, veterans heartily endorsed the pre-payment idea for themselves and their dependents. As American industry began to convert from a wartime economy to peacetime production, unions assumed strong positions in their negotiations for employee benefits. Employer tax exemptions for health and welfare contributions

further enhanced the movement. A favorable climate for union fringe benefit demands was thus created. As a final measure, when the U. S. Supreme court late in 1949 ruled that as part of the Taft-Hartley Act, employers had to bargain on welfare issues, the pre-payment concept caught on throughout the nation, sweeping every aspect of American industry. The Blue Cross and Blue Shield Plans grew rapidly.

Emergence of Competition

Up until now, the commercial insurance companies ahead been largely indifferent to the potential of health insurance. Seeing that it worked, the commercial companies were quick to include health insurance in their insurance packages offered to large groups. By 1963, more than 900 insurance companies were actively writhing health insurance.

The impact of the commercial insurers' practices was to significantly change the environment in which the Blue Cross and Blue Shield Plans operated. In the early years, for example, the Plans followed the practice of "community rating," meaning that the risk was spread over the entire subscriber population. The Plans offered everyone in the community the same benefits at the same price, regardless of their age, health status or employment. The commercial insurance companies entered the market with a different system known as "experience rating," which in its simplest form means that rates are based upon the amount of services the group uses and the risk represented by that particular group. The effect of this change was that the commercial insures could offer lower rates to groups with younger and healthier employees. The Blue Cross and Blue Shield Plans were forced to modify their practices by adopting experience rating in order to compete.

The Plans did not abandon the smaller groups and individuals who constitute higher risks, however. They still cover individuals and small groups whom the commercials avoid. They do not cancel coverage because of high use or poor health.
The Plans differ from commercial insurers also in their strong hospital and physician relations; they contract with hospitals and physicians to provide services, and they pay contracting providers directly, whereas the commercial companies simply pay the policy-holder a stated number of dollars. The Plans return a greater percentage of premium payments to subscribers in the form of benefits. Governed by boards of directors consisting of a majority of public representatives, they have a strong obligation to their communities and their subscribers which the commercial companies do not necessarily share.

The Changing Environment

Costs of hospital and medical care increased steadily and rapidly, especially after the advent of Medicare and Medicaid in 1966. Spurred by the economy, inflation, the infusion of money through government programs, the development of new technology, and the availability of insurance to cover medical advances, costs increased each year, sometimes as much as 15% per year. Cost containment became of paramount importance. The Blue Cross and Blue Shield Plans led the way in cost containment efforts, being first to support area-wide planning, for example, and encouraging the shift from in-patient to out-patient care.

Another example is the Medical Necessity Program to define and apply good standards of practice to the utilization of services. The Plans were in the lead in the development of "managed care'" including utilization review, second opinion and pre-admission certification programs. They developed new ways of paying hospitals. They developed health maintenance organizations and, more recently, preferred provider arrangements.

The early 1980's witnessed a revolution in the way health care is delivered and financed in the United States. Old partnerships and relationships evaporated as competition became the order of the day. For-profit hospital chains emerged, as did a wide variety of ambulatory care facilities, both hospital-affiliated and freestanding. Both providers and insurers began developing health maintenance organizations and preferred provider organizations. Hybrids of there are beginning to appear. Pressure from cutbacks in Medicare and Medicaid have forced providers to seek other sources of income at a time when they cannot turn to privately insured patients to make up the difference. Even non-profit hospitals are establishing multi-hospital systems in order to compete, and hospital corporations are getting into insurance. The trend among large employers has been toward self-insurance, and this has created a variety of administrative service arrangements.

While all these competitive pressures and complex relationships have changed the structure of the organization and the way the Plans operate, they have not changed the basic philosophy of the Blue Cross and Blue Shield Plans, that of serving the community by providing payment for quality, affordable health care coverage on a non-profit basis.

Move Toward National Unity: The Blue Cross Association

1937 -- The American Hospital Association established the Commission on Hospital Service -- a forerunner of both the Blue Cross Commission and the Blue Cross Association. The Commission, located in Chicago, provided information and advice for developing non-profit, voluntary health plans, served as a clearinghouse for ideas; and studied hospital and pre-payment plan financing.

1939 -- The Blue Cross symbol -- designed by E. A. van Steenwyk, President of the St. Paul, Minnesota Plan -- officially was adopted by AHA as the national emblem for the Plans which met AHA guidelines.

1941 -- The AHA dissolved the Commission on Hospital Service and replaced it with the Hospital Services Plan Commission (HSPC). The HSPC was financed with dues from the Plans rather than through AHA, and it took on responsibilities for research and Plan coordination.

1946 -- The Blue Cross Commission was created by AHA to replace HSPC. The Commission, also financed by Plan dues, help formulate and establish national Plan policies, as directed by the Plans at their annual meetings.

1948 -- The AHA incorporated the Blue Cross Association in Chicago to begin a subsidiary organization called Health Service, Inc. (HSI).
Through voluntary contributions by the Plans, HSI was organized as a Plan-owned insurance company to write uniform national health contracts.

1949 -- The Inter-Plan Service Benefit Bank was created as a clearinghouse to serve Blue Cross members who happened to be hospitalized or receive health care outside their local Plan areas, and the Blue Cross Commission in chicago took overs its administration.

1951 -- The Inter-Plan Transfer Agreement, which provides for transfer of membership between Plans without loss of benefit continuity, became operative and was administered by the Blue Cross Commission in Chicago.

1956 -- The Blue Cross Association was thoroughly reorganized and set up in New York City with responsibilities for national enrollment, advertising and federal government relations. It also assumed responsibility for administering the federal Military Dependents Coverage program, known as CHAMPUS.

1957 -- The Blue Cross Association established Inter-Plan private telecommunications wire service to streamline Inter-Plan claims and transfer communications. At this point, the Inter-Plan Bank and Inter-Plan Transfer administrative work was transferred from the Blue Cross Commission to the Association in New York.

1960 -- The Blue Cross Association assumed administrative and coordinating duties for the Federal Employee Health Benefits Program (FEP).

1962 -- The AHA dissolved the Blue Cross Commission, and the Blue Cross Association moved out of its subsidiary role and into a partnership role with AHA. This charge created a single, strong national association to represent the Plans, rather than two weaker national organizations in New York and Chicago. Under the new organization, the Blue Cross Association was directed by a twenty-five member Board of Governors consisting of 11 District Governors and 11 Members-at-Large, elected by the Plans, and three AHA Governors, nominated by AHA.

1962 -- Walter J. McNerney became the President of the Blue Cross Association, succeeding James E. Stuart.

1964 -- The Blue Cross Association established a Washington office and hired a Washington representative in anticipation of increased government interest in health pre-payment.

1965 -- The National Labor Office was begun in Washington by the Blue Cross Association to improve liaison between Blue Cross and national labor union leaders.

1966 -- Blue Cross contracted with the federal government as principal Medicare intermediary for hospital and other institutional stays by the elderly. The Blue Cross telecommunications system at Association headquarters in Chicago began handling all claims communication between the Plans and the Social Security record center in Baltimore.

1972 -- Formal ties with the American Hospital Association were severed. The name, trademark and Plan approval program were transferred from AHA to Blue Cross Association. A new stylized blue cross symbol was introduced.

History of the Blue Shield Association

1946 -- Nine Blue Shield Plans formed the Associated Medical Care Plans, forerunner of the National Association of Blue Shield Plans. The nine Plans were located in California; DesMoines, Iowa; Detroit, Michigan; Kansas City, Missouri; Omaha, Nebraska; Newark, New Jersey; Columbus, Ohio; Portland Oregon; and Camp Hill Pennsylvania.

1946 -- Frank E. Smith was named director, and served until 1954.

1947 -- During the first year of operation, the number of affiliated Plans jumped from the original nine to 45 Blue Shield Plans. Subscriber enrollment tripled to nearly 6 million.

1948 -- Blue Shield symbol was adopted by the Association and Plans.

1950 -- By 1950, there were 72 Blue Shield Plans with over 19 million enrolled.

1950 -- The blue shield symbol was officially adopted as reflected in the change of the name to Blue Shield Medical Care Plans, later (1960) to National Association of Blue Shield Plans, and (in 1976) to Blue Shield Association.

1950 -- A national service agency was established as a subsidiary of the Association, originally called Blue Shield Service,Inc., later changed to Medical Indemnity of America (MIA). The new organization functioned as a working arm of the Blue Shield system in writing coverage for national account groups under certain circumstances. MIA was able to underwrite gaps in coverage in national accounts caused by lack of uniformity among Plans created by different state laws and regulations.

1955 -- John W. Castellucci was named Executive Director (later named President). He served until 1971.

1971 -- Ned Parish served as President from 1971 to 1976.

1976 -- William E. Ryan served as President from 1976 until BSA's consolidation with Blue Cross Association in 1978.

National Merger

1978 -- The staffs of Blue Cross Association and Blue Shield Association were consolidated under one president, though each association retained its own board. Walter J. McNerney became President and William E. Ryan, Senior Executive Vice-President of both organizations.

1980 -- The associations moved to 676 N. St. Clair Street, Chicago.

1981 -- Bernard R. Tresnowski was appointed President, succeeding Walter J. McNerney.

1982 -- Blue Cross Association and Blue Shield Association were merged into one corporation with one board effective 7/1/82.

1982 -- HSI and MIA merged to become BCS Financial Corporation, the parent corporation for the BCS Insurance Company.

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THE FLORIDA STORY

In 1944, as public demand grew for adequate hospital care like that offered to members of the armed services, the Florida Health Services Corporation opened a four-person office in Jacksonville to offer groups a pre-payment hospital care plan. In 1946, the Florida Medical Services Corporation introduced a group plan to cover doctor bills. By 1951, they had adopted the Blue Cross and Blue Shield names, respectively, and were offering the public non-group enrollment statewide.

The two organizations began administering various government programs in the mid-1950's, and in 1966 became the primary administrator of the new Medicare program in Florida. Florida's Blue Cross and Blue Shield Plans consolidated in 1980, enabling them to operate more efficiently while developing innovations like health maintenance organizations, preferred provider organizations and cost containment programs.

ACCOUNTABLE TO THE PUBLIC

In 1982, the organization became a mutual insurance company, which gave it greater financial flexibility to compete and operate more efficiently, and to fund innovative programs to benefit the public. Also, policyholders gained voting rights in the corporation.

Fifteen to 21 policyholders form the company's board of directors. A majority of them are from non-health care fields -- law, business, banking, education, economics -- to ensure that the organization is publicly accountable.

FLORIDA'S RECOGNIZED LEADER

Blue Cross and Blue Shield of Florida is the largest provider of health care insurance in the state. Employing approximately 5,000 people, we serve more than three million Floridians in some capacity. We hold the position as the state's leading health insurer because of a long-standing commitment: offer the highest quality health care products and the lowest possible price. Dedicated to that purpose, our employees work hard to provide superior customer service and meet the complex and changing needs of the people who count on us.

WORKING FOR EVERYONE

Blue Cross and Blue Shield of Florida is doing more than any other health insurer in the state to help control rising health care costs. Our expertise in the economics of health care delivery is widely recognized by government, industry and the public, as shown by our involvement with the Governor's Hospital Cost Containment Board.

Our company does more than just collect premiums and pay claims. We work with doctors, hospitals, employers and government agencies to keep costs down, and it helps all Floridians, not just our subscribers.

We're a household name, partly because of our strong community ties. For more than 50 years, we've developed our products around the special needs of the communities they were meant to serve. We know our neighbors.

MEETING THE CHALLENGE

With profound concern for serving people's health needs, Blue Cross and Blue Shield of Florida has the most innovative products and cost control programs in the state which include the largest PPO (Preferred Provider Organization) network in the state and the Health Maintenance Organization (HMO). No other insurer can match our accomplishments in scope or measurable effectiveness.

SOME OF WHAT WE OFFER

Blue Cross and Blue Shield of Florida offers individual and group health insurance products, as does its HMO network, which also provides financing. The corporation offers life insurance and related products.

COMPLEMENTARY COVERAGE

Often called a Medicare supplement, this serves Floridians age 65 or older who are covered by Medicare but need additional coverage it doesn't provide.

DIMENSION II

This comprehensive, major medical program helps persons under 65 pay for hospital and doctor bills and other needs such as ambulance service. Our policyholders share the costs through deductibles and co-insurance up to a maximum out-of-pocket amount.

PREFERRED PATIENT CARE

People who take advantage of Preferred Patient Care, our Preferred Provider Organization networks, share medical costs through deductibles and co-insurance, but they receive higher comprehensive benefits than if they use non-participating physicians and hospitals.

TEMPORARY PROTECTION

We offer a comprehensive major medical policy for folks who don't need permanent insurance, such as people who are between jobs. Because it's designed primary to cover accidents and emergency illness, premiums are about half the cost of permanent coverage.

CONTINUED PROTECTION PRODUCT

Regardless of their health, anyone who leaves group protection may switch to this product without having to satisfy another pre-existing health condition period.

NEW RESIDENT PRODUCT

We offer the same service, described in the preceding paragraph, to new Florida residents who were covered by another Blue Cross and Blue Shield plan.

GROUP PRODUCTS

TRADITIONAL INSURANCE

This lets employees choose their own providers, and it covers hospital and doctor bills and supplemental charges. Covered medical or hospital expenses usually are subject to a deductible and co-insurance up to a maximum amount. Benefits depend upon group size and subscriber needs. Some of the distinctive product variations are Business Employers Trust (BET), for two to nine employees, and Traditional Plus, which has several cost containment features for groups of 10 or more employees.

PREFERRED PROVIDER ORGANIZATION (PPO)

With our PPC, Preferred Patient Care, subscribers may choose any hospital or physician, but they receive greater benefits if they select providers contracting with PPC. Point of Service is PPO product that gives employees freedom of choice in selecting providers, with increased benefit coverage if they choose PPC physicians and hospitals, and standard traditional coverage if a non-PPC provider is chosen.

HEALTH MAINTENANCE ORGANIZATION (HMO)

HEALTH OPTIONS, INC., provides comprehensive health care services in exchange for a fixed, prepaid fee. Members have access to thousands of quality physicians, and some of Florida's most respected hospitals participate. HEALTH OPTIONS offices are located in major metropolitan areas -- members choose a local primary care physician who provides or approves their health care. In emergencies, they can receive are anywhere in the world, 24 hours a day.

LIFE INSURANCE

We offer life, accident and disability insurance through our subsidiary, Florida Combined Life Insurance Company, Inc.

DENTAL ASSISTANCE PROGRAM

Our dental coverage emphasizes preventive services and encourages families to visit their dentist regularly. The program is designed to pay 100 percent of preventive services, 80 percent of other services after a deductible is satisfied, and no less than 50 percent of non-preventive covered services.

ORGANIZATIONAL RESPONSIBILITIES

PRESIDENT:

The President is responsible for the conduct of the Plan within the policy guidelines set by the Board of Directors. In addition to the operation, the President is also chief spokesman and accountable for the implementation of corporate objectives and specific results within each of those objectives.

EXECUTIVE STAFF:

Composed of the President and those persons reporting directly to him, the Executive Staff is responsible for Strategic Planning and Management, leading and coaching subordinates, and supporting and strengthening relationships among groups and individuals.

GOVERNMENT PROGRAM OPERATIONS:

The Government Programs Operations Group is responsible for processing government program claims, servicing beneficiaries and providers; and exploring business opportunities.

PRIVATE BUSINESS OPERATIONS:

The Private Business Operations Group is responsible for providing Superior Customer Service in processing Blue Cross and Blue Shield claims, customer inquiries, and membership and billing documents in accordance with contracts.

HEALTH MAINTENANCE ORGANIZATION:

The Health Maintenance Organization is responsible for marketing and delivering access to quality care at reasonable prices to Floridians who want and need this form of health care alternative.

MARKETING AND FINANCE:

The Corporate Marketing and Finance Group is responsible for providing health and life insurance products and related services to meet the needs of the Florida marketplace at reasonable cost while ensuring the long-term financial effectiveness of the corporation.

HEALTH INDUSTRY SERVICES:

The Health Industry Services Group is responsible for developing and maintaining programs that contain health care costs; designing and implementing medical reimbursement policies; maintaining effective provider, professional, political and public relationships; increasing the volume of automated ("paperless") claims; and designing and implementing efficient, innovative, alternative delivery systems, such as PPO's and Managed Care programs.

HUMAN RESOURCES:

The Human Resource Division is responsible for helping management acquire, deploy, develop and maintain employees with the competencies and commitment needed to meet the challenges facing the corporation in a stimulating, innovative and creative work environment.

SPECIAL PROGRAMS:

The Special Programs Division is responsible for recommending innovative and creative approaches to all aspects of Superior Customer Service throughout the corporation, and for auditing the procedures and controls of the organization.

CORPORATE OBJECTIVES

1. **CUSTOMER/PUBLIC SERVICE, SATISFACTION AND SUPPORT** - Develop and maintain customer, public and governmental satisfaction and support by providing superior service.

2. **FINANCIAL EFFECTIVENESS** - Operate a financially strong organization through efficiency of operations with adequate reserves for contingencies and business development.

3. **MARKET** - Achieve an optimum share of the Florida private and government health care coverage markets in terms of benefit levels and population covered or served.

4. **NATIONAL SYSTEM** - Support achievement of our Corporate Objectives and the broader needs of society for high quality health care, at reasonable cost, by participating and cooperating effectively with the National Association and other Plans.

5. **OPERATIONAL AND ORGANIZATIONAL EFFECTIVENESS** - Develop and maintain an effective and progressive organization that will achieve the Corporation's planned business results, by attracting, developing and retaining high quality employees, maintaining a sound organizational structure, applying sound management processes and practices, and providing necessary physical resources and systems.

6. **PROVIDER/PROFESSIONAL - SERVICE AND SUPPORT** - Obtain the acceptance and participation of providers and professionals in the financing and delivery of quality health care to our members at a reasonable cost for sustainable competitive advantage.

7. **PUBLIC AND GOVERNMENT UNDERSTANDING AND ACCEPTANCE** - Gain public and governmental understanding, acceptance and support of corporate policies, programs and actions.

We will accomplish our Corporate Objectives by observing the following:

CORPORATE VALUES

- Respect for the Customer

  We will develop and market products and services that are responsive, adaptive and flexible in meeting our varied customer needs and wants in a timely, leadership fashion. We will provide superior customer service as our ultimate goal in all dealings with our subscribers and beneficiaries.

- Respect for the Individual

  We will treat all people as individuals, with the respect, dignity, and consideration due them as members of a free society. We will build and maintain a stimulative, innovative and creative work environment that will encourage and reward individual and team achievement. We will provide opportunities for advancement and a high sense of personal commitment and satisfaction for all employees.

- Pride in Excellence

  We will strive for excellence in the quality of work we perform and the quality of products and services we offer. Excellence is found in caring, in trying, in doing. It is the standard against which all our efforts will be measure.

EXECUTIVE STAFF - BIOGRAPHIES

William E. Flaherty is the *President and Chief Executive Officer.* Prior to joining the Florida Plan in 1979 as president and chief executive officer, Mr. Flaherty was president and chief executive officer of Blue Cross and Blue Shield of Delaware. He was executive vice-president of Blue Cross and Blue Shield of Michigan from 1972 through 1975.

Mr. Flaherty is an advocate of competition among health care providers as an alternative to the regulation of health care by government. Under his leadership, the company employs a strategy that recognizes managed care programs as the most effective means of controlling health care costs.

Mr. Flaherty's philosophy is to keep Blue Cross and Blue Shield of Florida competitive in all markets it serves through effective management of medical costs and effective program administration. As part of this philosophy, Mr. Flaherty is active on various boards, organizations and task forces on the local, state and national levels.

He serves as a member of the Board of Directors and Executive Committee of the Blue Cross and Blue Shield Association and its Nominating and Strategic Planning Committees. He also serves on the Managed Health Care Council and the Board of Health Plans Capital Service Corporation.

At the state level, he serves on the Governor's Task Force on Private Health Care Responsibility and recently as a member of the Governor's Committee on Workforce 2000 and its Education Subcommittee.

He is also past director of Florida's Hospital Cost Containment Board; the Governing Board of Health Systems Agency (Area 3); member of the Governor's Task Force on Competition and Consumer Choices in Health Care; the State Health Policy Task Force; and the Management Advisory Council for Health Rehabilitative Services (HRS).

Flaherty is a member of the Florida Council of 100; a member of the Board of the National Conference of Christians and Jews, Jacksonville Chapter; and a member of the University of North Florida's Foundation Board.

A graduate of Wayne State University in Detroit, MI, Flaherty also did graduate work in economics.

Michael Cascone, Jr., is *Executive Vice-President, Private Business Operations.* Mr. Cascone is an advocate of a quality work environment and team approaches to decision making and problem solving. At Blue Cross and Blue Shield of Florida, he is responsible for Legal Affairs, Government Relations, Information Systems and Private Business Operations.

He was instrumental in Blue Cross and Blue Shield of Florida's realignment by customer group, which positions the company to best meet the service needs of its customers. Mr. Cascone earned a bachelor of arts degree in mathematics from Jacksonville University. In 1985, he completed the Harvard Business School Advanced Management Program.

Kenneth C. Otis, II is *Executive Vice-President, Marketing and Health Care Services.* Mr. Otis played a key role in the revitalization of Blue Cross and Blue Shield of Florida's health maintenance organization, Health Options, and its integration with the company's other businesses. Health Options provides a product line that gives customers a wide variety of choices with an array of cost containment features.

Before coming to Blue Cross and Blue Shield of Florida, Mr. Otis was executive vice-president of Colonial Penn Group in Philadelphia where he was responsible for Colonial Penn's life, health and financial service companies.

Mr. Otis is a graduate of Yale with a MBS from the Harvard Graduate School of Business. He is chairman of the Hospital Cost Containment Board and Tax Watch.

Thomas E. Albright is *Senior Vice-President and Chief Marketing Executive.* Mr. Albright joined Blue Cross and Blue Shield of Florida in August, 1987 as vice-president of Health Industry Services, Field Operations. In December, 1987, he was promoted to senior vice-president of HIS. In November, 1988, he assumed marketing responsibilities chief marketing executive.

Before moving to Florida,Mr. Albright served as vice-president of Prudential Insurance Company in Minneapolis, NM, and was responsible for regional group operations. He also serves as senior vice-president of PruCare, Prudential's HMO subsidiary. Mr. Albright is a graduate of Villanova University.

Antonio J. Favino is *Senior Vice-President, Government Program Operations.* Mr. Favino has worked for Blue Cross and Blue Shield Plans in New York and Florida since 1955.

Prior to joining Blue Cross and Blue Shield of Florida in 1979, he was assistant vice-president for Beneficiary and Provider Services, and assistant vice-president for Part A and B Medicare Operations for Blue Cross and Blue Shield of Greater New York. From 1955 to 1974, Mr. Favino served as vice-president of Regular Business Operations, vice-president for Government Programs for Blue Shield of Greater New York.

At the Florida Plan, he served as director of government Programs and as director of Medicare Part A Claims until he was appointed as vice-president of Medicare Part A in March, 1983. Mr. Favino received a bachelor of arts degree from New York University.

Richard L. Thomas is *Senior Vice-President of Finance and Treasurer.* Mr. Thomas joined the Florida Plan in May, 1988 as vice-president of Finance and Planning. In October, 1989, he was named senior vice-president of Finance and Treasurer.

Before coming to Blue Cross and Blue Shield of Florida, Mr. Thomas served as senior vice-president and chief financial officer with Bank Western in Denver, CO. Prior to that, he held various positions with Central Bancorporation, also in Denver, including chief financial officer, executive vice-president and chief operations officer.

Thomas is a certified public accountant and also worked in public accounting with Peat, Marwick, Main. He earned a bachelor of science degree in business administration and accounting from Kansas State University and a MBA degree in business administration from the University of Iowa.

Thomas is a member of the Financial Executive Institute, American Institute of Certified Public Accountants, and Colorado Society of Certified Public Accountants.

Bruce A. Davidson is *Vice-President, General Counsel and Corporate Secretary.* Since October, 1988, Mr. Davidson has served as vice-president, General Counsel and Corporate Secretary of the Florida Plan.

Before joining Blue Cross and Blue Shield of Florida, Mr. Davidson worked for Sentry Insurance Group in Stevens Point, WS, for 10 years. The various titles and positions he held include vice-president and general counsel, division vice-president responsible for a five-state operation, and vice-president of claims.

Mr. Davidson graduated from Occidental College in Los Angeles, CA, with a bachelor of arts degree in political science and history. He obtained his juris Doctor degree-with-distinction-from Duke University Law School.

Michael R. Johnson is *Vice-President Human Resources.* Michael R. Johnson came to Blue Cross and Blue Shield of Florida in February, 1990. In July, 1990, he was appointed vice-president of Human Resources.

Prior to joining Blue Cross and Blue Shield of Florida, he held the position of vice-president, Human Resources, for First Data Resources, which is a subsidiary of American Express. His other previous professional experience includes positions and Xerox Corporation and Wang Labs, Inc. Mr. Johnson received his bachelor of science in mathematics and also a master of arts degree in mathematics/education from the University of Missouri in Kansas City.

EXECUTIVE & SENIOR STAFF LISTING
AS OF APRIL, 1991

NAME	TITLE
FLAHERTY, William E.	President
ROGERS, Jan	Administrative Assistant
ALBRIGHT, Thomas E.	Sr. V.P. & Chief Marketing Executive
Glover, Evelyn	Executive Secretary
BRODSKY, Ernest N.	V.P., Product Management
Batts, Vickie	Executive Secretary
BURCHETT, Peter	Regional V.P., Central Region
Cardona, Maureen	Executive Secretary
CASCONE, Michael Jr.	Executive V.P., PBO Operations
Killebrew, Joan	Executive Secretary
CASSADY, George E.	V.P., Org. Development Consulting (PBO)
Wood, Maxine	Executive Secretary
DAVIDSON, Bruce	V.P., General Counsel & Corporate Secretary
Hodges, Terrie	Executive Secretary
DAVIS, Stephen C.	V.P., Corporate Project Development
Blaylock, Marilyn	Executive Secretary
DEMERY, Carl J.	V.P., Financial Planning & Perf. Reporting
Thomas, Patty	Executive Secretary
DINGFIELD, Dave	V.P., Information Systems and Operations
Wood, Sherry	Executive Secretary
DiCENZA, Judith A.	V.P. & Actuary, Actuarial & Underwriting
Carter, Faye	Executive Secretary
DOWNS, Harry E.	V.P. Information Systems
Teter, Nancy	Executive Secretary
DUNN, Tom	V.P., National/Corporate Accounts Operations
Hirst, Patty	Executive Secretary
FAHNER, Hal	V.P., Corporate Marketing
Helms, Eleanor	Executive Secretary

NAME	TITLE
FAVINO, Antonio J.	Sr. V.P., Governnment Program Operations
Bloom, Claudia	Executive Secretary
FUENTES, Fabian B.	V.P., National Accounts Marketing
Purvis, Darlene	Executive Secretary
GRANTHAM, L. Joseph	V.P., Corporate Project Development
McMillan, Debbie	Executive Secretary
HIGHTOWER, Michael R.	V.P., Governmental & Legislative Relations
Steckley, Linda	Executive Secretary
HOUSH, Skip	Regional V.P., Northwest Region
Hiers, Cathy	Executive Secretary
HUBBARD, Tony A.	V.P., Corporate Medical Policy
Evans, Kacy	Executive Secretary
JENNINGS, Paul	V.P., Direct Marketing
Stubbs, Judith	Executive Secretary
JOHNSON, Michael R.	V.P., Human Resources Division
Smith, Sybil	Executive Secretary
LIPTAK, Walter	V.P., Life Company Operations & President, Florida Combined Life
Seefried, Dawn	Executive Secretary
LUFRANO, Robert I.	V.P., Medical Affairs
Luman, Phyllis R.	Executive Secretary
MENHEIM, Dudley	Regional V.P., West Coast Region
Gray, Kimberly	Executive Secretary
OTIS II, Kenneth C.	Executive V.P., Marketing & Health Care Service
Fauth, Jill	Executive Secretary
Payne, Larry L.	V.P., Local Group Market Operations
Rhoden, Joan	Executive Secretary
PIES, Harvey E.	V.P., Special Counsel for Managed Care Systems
Shirah, Gwen	Executive Secretary

NAME	TITLE
PRALLE, Robert F. Tirado, Daphne	V.P., Corporate Accounts Executive Secretary
REED, William H. Open	V.P., Corporate Accounts Marketing Executive Secretary
RICHARDS, Charles R. Felker, Debbie	V.P., Finance Executive Secretary
SCOTT, W. Charles Cole, Sharon	V.P., Medicare Part B Operations Executive Secretary
SEBOK, Robert S. Parker, Amy	V.P., Group Sales Executive Secretary
SELLERS, Kenneth G. Brannen, Laura	Regional V.P., Northeast Region Executive Secretary
SMITH, Richard (Dick) Reddy, Alicia	Regional V.P., Southern Region Executive Secretary
STANLEY JR., Thomas W. Witt, Vicki	V.P., Program Management Executive Secretary
THOMAS, Richard L. Herren, Cathy	Sr. V.P., Treasurer & Chief Financial Officer Executive Secretary
VAN DYKE, Donald J. Self, Janice	V.P., Direct Market Operations Executive Secretary
WASHINGTON, Al G. Alford, Paige	V.P., Organizational Development Consulting Executive Secretary
WILLIAMS, Patricia A. Paxton, Pat	V.P., Medicare Part A. Executive Secretary

The "Players" In Health Care

1. Providers of Care: Doctors & Hospitals
2. Financiers of Health Care: BCBSF & Others
3. Patients: Also Known As Subscribers

What Is The Role Of Blue Cross & Blue Shield In Today's Marketplace?

Q: Is BCBSF just another insurance company?

A: No, BCBSF is an industry leader in providing managed care to our customers and their employees. We are dedicated "health care specialists" in providing managed care.

Q: What is "Managed Care"?

A: Bill Flaherty, the president of BCBSF defines "managed care" as follows:

> **Managed Care** refers to all products and programs that manage the **cost** and **use** of health care.

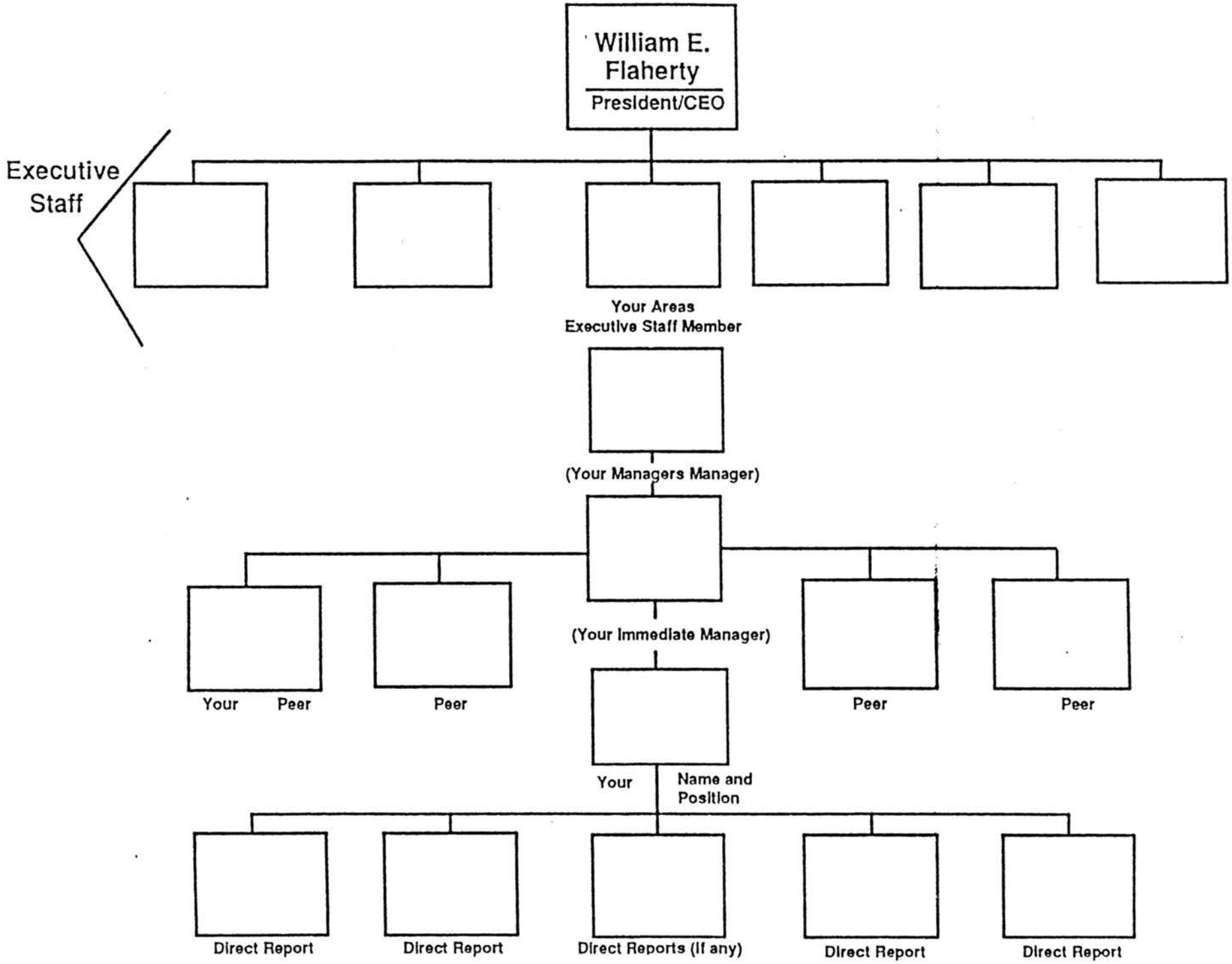
Q: Why are the cost and use of health care so important in "Managed Care"?

A: The value of the cost and use of health care in "Managed Care" may be best explained by the following "Managed Care Formula":

$$C = Q\,(P \times U)$$

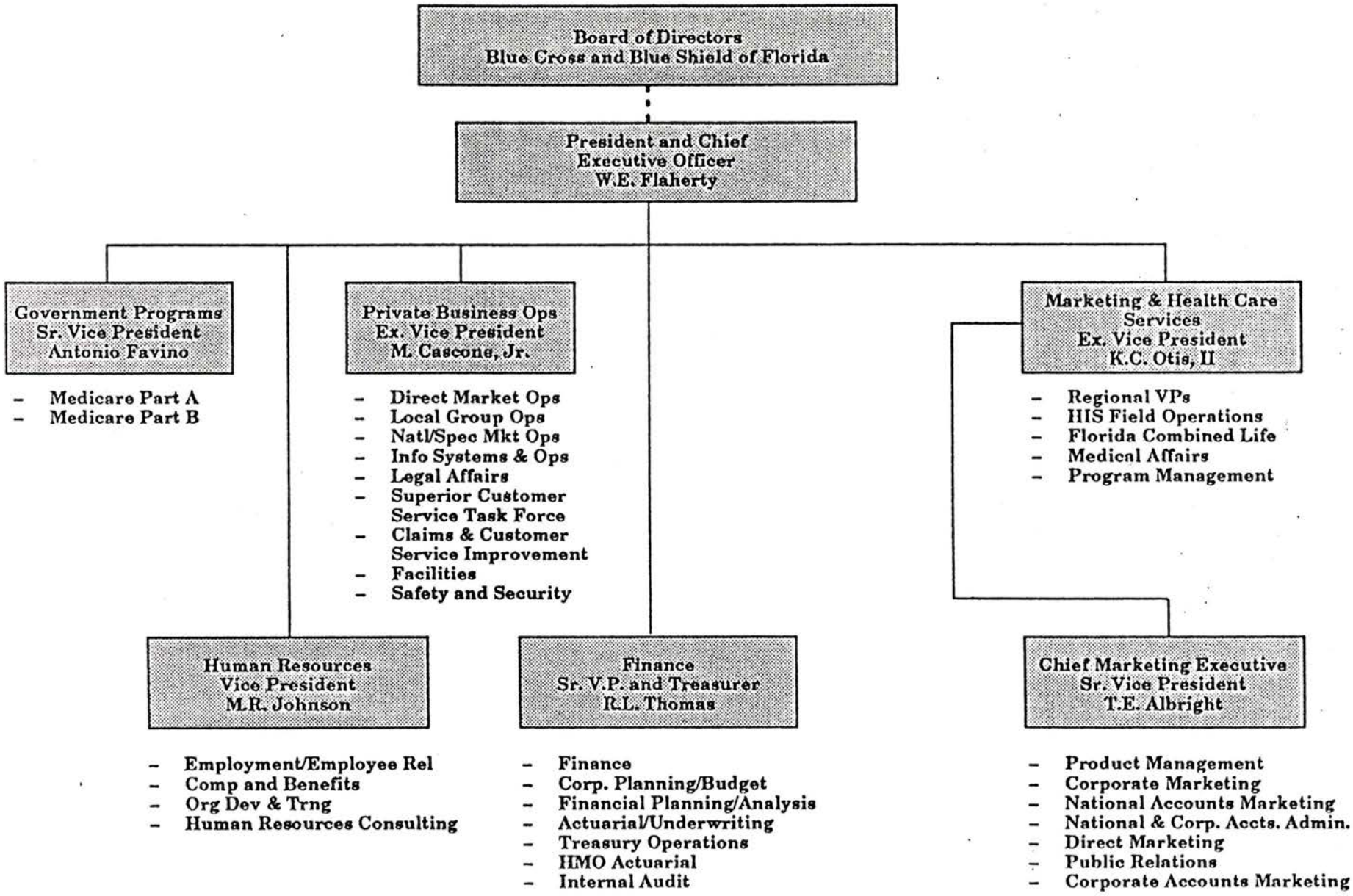
The **total cost** of health care =

- The quality of care provided
- x The price of the programs and services rendered
- x The frequency, duration and location of programs used.



This organizational Chart is for your use only, and is designed to help you begin to establish relationships in your

BLUE CROSS AND BLUE SHIELD OF FLORIDA
ORGANIZATIONAL CHART



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ORGANIZATION CHART

At BCBSF, we highly value development of relationships with peers, management and throughout the organization.

To build these relationships, you need to know who your peers and managers are. Now that you've seen the corporate organizational chart, we're going to ask you to give a try at developing one more specific for your work unit.

Attached is a blank Organizational Chart with a sample chart and the corporate organizational chart. Between now and Friday, we would like for you to work with a peer or perhaps your manager or supervisor and try to complete the chart. It may not be easy, but give it your best shot. You will be voluntarily reviewing a couple of them at the group presentation Friday.

What we are looking for is:

- Who is the President and CEO?
- Who is the Executive Staff member associated with your unit?
- What other officers are associated with your unit?
- Who are your immediate director(s) and managers(s)?
- Who are your peers, and what are their jobs?
- Who are your direct reports, if any?

Any of this information you can find out would be helpful to your transition into the work area.

If you have any questions during the week, call Susan Porter at 791-6832.

BCBSF Managed Care Strategies

* Monitor the cost of care derived from BCBSF products

* Select providers for cost effectiveness & quality

* Pre-authorize non-network care to control the cost and use of services not negotiated by BCBSF

* Integrate a full delivery system for all BCBSF products

* Shift/share risk with BCBSF doctors & hospitals

* Reward network doctors & hospitals for efficiency and quality of care provided

Managed Care Components

*** Utilization Management:**

Products and programs that monitor the appropriateness of health care services and the environments in which they are administered. Examples include:

- Pre-admission Certification
- Case Management
- Discharge Planning

*** Reimbursement:**

The means by which doctors & hospitals are payed for services rendered. Examples include:

- Capitation
- Diagnosed Related Group (DRG) Based Payment Schedules

*** Network Design:**

Programs that provide access to doctors, hospitals, pharmacies and other health service related centers who have contracted with BCBSF to offer quality health care services at pre-negotiated rates. Examples include:

- Preferred Patient Care (PPC) Network
- Health Options Network
- Payment For Hospitals Services (PHS) Network
- Payment For Professional Services (PPS) Network
- Mediscript Network
- Dental Assistance Plan (DAP) Network

Managed Care Components (Continued)

*** Quality Management:**

Programs designed to monitor the quality of health care offered to BCBSF subscribers. Examples include:

- Provider Credentialing
- Outcome Review
- Quality Screening

*** Medical Cost Analysis**

Programs designed to monitor the cost efficiency of health care provided to BCBSF subscribers. Examples include:

- Hospital & Provider Audits
- PPC Savings Reporting

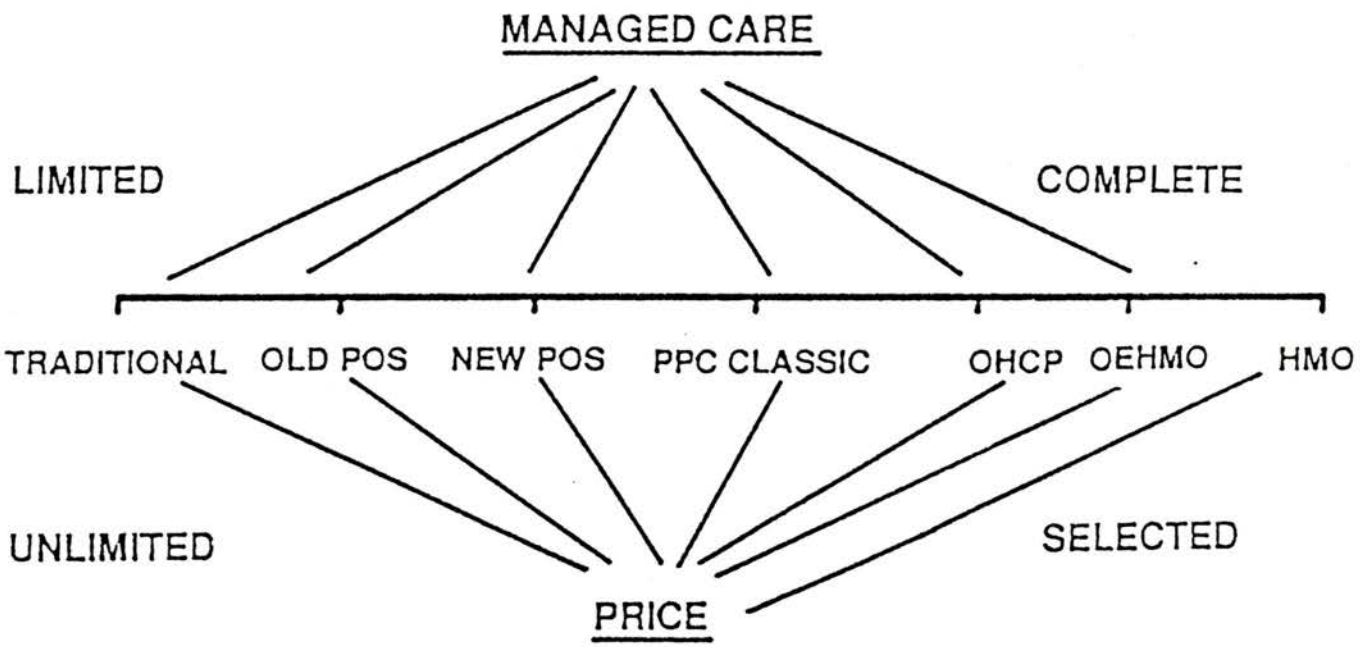
*** Benefit Design**

Specifications by which BCBSF products pay for health care services used by our subscribers. Examples Include:

- Deductibles
- Co-Insurance (In & Out of the BCBSF Network)
- Copays
- Maximum Out of Pocket Allowances

PRODUCT PORTFOLIO SPECTRUM

BCBSF has a broad spectrum of product lines and managed care products.



HISTORY

OF

BLUE CROSS AND BLUE SHIELD

From: Blue Cross
Blue Shield
Association

INTRODUCTION

Welcome to Blue Cross and Blue Shield of Florida. We are proud to have you as a member of our employee family. We look to each member of our team for the skill to contribute and the potential to grow while helping us to achieve our common goal -- the best possible health care protection and quality service to our subscribers.

To be successful, a company must do more than just maintain its current condition -- it must constantly strive to improve itself. By financial measure, it strives to increase sales and earnings. By customer measure, it strives to provide increasingly better products and service. By public measure, it seeks the support of its publics. And by any measure, a company can achieve success only through the commitment and contributions of its people.

Because we believe that the ultimate success of our organization is directly dependent on people, we recognize that our employees are our most valuable asset. This concept is one of our basic corporate values. Basically, it comes down to treating employees with dignity; establishing a climate of trust, cooperation and employee involvement; and providing an environment for open, timely communication, job satisfaction, financial security and opportunities for growth and accomplishment.

There is a lot to learn about our organization. Most of it you will learn gradually, as you come to work every day. The Corporate Orientation Program and supplemental materials highlight some of the basic information you will need to know as you begin your career with us. It is not intended to alter or replace official policies described in the Human Resource Policies and Procedures Manual or other company documents. The policies and practices summarized herein are subject to change as deemed advisable and/or necessary by management. This information is not to be considered a part of any employment agreement with our employees.

Management personnel throughout Blue Cross and Blue Shield of Florida have been assigned Human Resource Policies and Procedure Manuals that are accessible to all employees. You are encouraged to review these policies and procedures with your immediate manager for clarification.

We are glad you are with us. Thank you for joining our efforts to provide the best possible services to the people of Florida. We hope that your career with us will be a long and rewarding partnership.

WHAT WE'RE ABOUT

OUR MISSION

We recognize that all members of society have a need for access to quality health care at a reasonable cost. The basic purpose of Blue Cross and Blue Shield of Florida is to help meet those needs by providing efficient and effective health care financing, administrative, and delivery services.

HELPING PEOPLE: HOW IT ALL BEGAN

The history of Blue Cross and Blue Shield is a story about Americans helping each other.

The Blue Cross idea began in Dallas, Texas, in 1929. The country was entering the Great Depression and the Baylor University Hospital was experiencing severe financial difficulties. This set the stage for a unique concept in health care. Justin Ford Kimball, the Dallas superintendent of schools, contracted with the hospital to pay $6.00 a year for each Dallas teacher. When a teacher became ill, he or she was hospitalized at Baylor free of charge for 21 days. The idea of pre-paid health care was born.

The Dallas idea lead to similar arrangements throughout the country, each involving a single hospital. By 1932, community-wide pre-payment plans began to emerge, offering subscribers a choice of hospitals. In 1939, more than three million Americans were involved.

The symbol of a blue cross came into being in 1932, when an executive of the St. Paul, Minnesota program started using it on company stationery. Other programs adopted it, and in 1939 it became official. As originally designed, the symbol was in the shape of the Geneva cross -- the international emblem for the relief of the sick and wounded. Superimposed on the cross was a seal of the American Hospital Association. In 1972, the symbol was changed by placing a human figure within the cross to better symbolize our primary focus on the people in the communities we serve.

The prepaid health care idea for hospital expenses was matched in 1939 by a pre-paid plan designed to cover physicians' services. Founded in California as the California Physicians Service, this system evolved from a number of county medical pre-payment bureaus that developed before the turn of the century in the northwestern United States.

Founded as separate organizations from Blue Cross, the physicians' services plans adopted the shield as their symbol because, throughout history, the shield has served to protect the body. Superimposed upon it is the knotty staff with the entwined serpents, known as the caduceus, the symbol of the Greek god of medicine which continues as the symbol of the physician today.

A NATIONWIDE NETWORK

Today, "Blue Cross" and "Blue Shield" are the names and symbols used by 73 independent companies, locally managed and governed, each with its own health care programs, products and policies. These companies, usually referred to as Blue Cross and Blue Shield plans, form a nationwide network or federation of autonomous corporations, each operating under the laws of their particular state. There are 92 "Blue Cross" and "Blue Shield" plans world wide.

Blue Cross programs, created to cover hospital expenses, have expanded their coverage into outpatient care, other institutional services and even home care. Blue Shield plans, established mainly to cover physician services, now provide benefits such as dental, vision and outpatient services.

SERVING 100 MILLION PEOPLE

As a federation of plans, Blue Cross and Blue Shield employ nearly 125,000 people. We serve about 100 million Americans in both the private and public sectors -- almost one of every two persons in this country. As a total entity, Blue Cross and Blue Shield Plans would rank among the largest corporations in the United States. We are larger, by far, than the 10 next largest commercial insurance companies in the country combined.

Each of the Plans works cooperatively with others, participating with one another on national accounts, an insurance program for federal employees, claims services for visiting subscribers from other states, and other efforts.

The Blue Cross and Blue Shield Association in Chicago is the Plans' coordinating agency. It speaks for them in matters of national concern; initiates and coordinates public education programs; contributes to cost containment efforts; and provides research, statistical, actuarial, marketing and other services. It also links the plans with a computerized telecommunication system.

Blue Cross and Blue Shield were formed to help people pay medical bills. Partly as a result of their ability to pay, Americans have had the best health care available anywhere in the world. To maintain this high standard, and keep health care affordable, is the challenge being faced by Blue Cross and Blue Shield.

HISTORY OF THE BLUE CROSS AND BLUE SHIELD ORGANIZATION

"Blue Cross" and "Blue Shield" have become household words in the United States. The familiar symbols are instantly recognized as representing protection from the costs of hospital and medical bills for millions of Americans.

The Blue Cross and Blue Shield organization is not a single company. Rather, it is a nationwide federation of 79 locally governed, autonomous corporations, each operating under state law as a non-profit service organization. (Each local corporation is known as a Plan.)

The pre-payment movement now known as the Blue Cross and Blue Shield organization grew up in local communities, gradually spreading to other communities, joining together at a regional or state level, and eventually forming a national organization to coordinate the activities of the local Plans.

The Blue Cross Plans were founded primarily to cover hospital expenses, though they have expanded their coverage into out-patient care, other institutional services and even home care. The Blue Shield Plans were established primarily to cover physician's services, though they too have expanded into other benefits, such as dental and vision care. In most areas, Blue Cross and Blue Shield Plans cooperate closely and many, a single management. Or they may share office space, conduct joint enrollment and billing functions. In other areas, they are separate organizations which overlap in the benefits they offer, or even compete with each other.

How did this pre-payment movement come about?

The Blue Cross Idea

During the 1920's, hospitals in several states offered their communities a new method of paying for hospital care in advance of need. The most successful of the Plans was at the Baylor University Hospital in Dallas, Texas, under the leadership of Justin Ford Kimball, Ph.D., Executive Vice-president of Baylor University. In 1920, a group of Dallas school teachers worked out an agreement with the University Hospital. For a monthly sum of $.50 per teacher, each was assured of receiving 21 days of care in a semi-private hospital room when needed.

Other groups of employees in the Dallas area joined the group. The Baylor program was described at the annual meeting of the American Hospital Association in 1931. The idea soon attracted nationwide attention and similar arrangements spread throughout the country. The deepening Depression gave impetus to the movement as millions of persons recognized the need to protect themselves from the devastating cost of illness.

At first, each plan involved only an individual hospital, but by 1932, community-wide agreements offering subscribers a choice of hospitals began to emerge. Among the first communities to have programs of this sort were Sacramento, California; Newark, New Jersey; and New York City.

In 1933, E.A. van Steenwyk, first executive of the Hospital Service Association of St. Paul, Minnesota, used a blue cross to identify his program on stationery, folders, and other printed material. The idea caught on, and other programs started using the same symbol. In 1939, the Blue Cross symbol was officially adopted by a commission of the American Hospital Association, which also developed membership standards which the Plans had to meet. Plan dues supported the commission from 1941 on.

In 1960, the Blue Cross Commission was replaced by the Blue Cross Association, which had been operating independently of the AHA since 1948, and was supported by dues from the Blue Cross Plans. In 1972, formal ties with the American Hospital Association were severed.

The design in the center of the Blue Cross symbol was revised in 1972 when the Blue Cross name, service mark, and approval program were transferred from the AHA to the Blue Cross Association. The stylized human figure in the center of the cross symbolizes all mankind and the role of the Plans in serving human needs.

Origins of the Blue Shield Concept

In the lumbering and mining camps of the Pacific Northwest at the turn of the century, employers contracted for medical services for their workers with individual physicians who were paid a monthly fee. That arrangement led to establishing "medical service bureaus" composed of groups of physicians contracting their services to employers. The workers then had the freedom to choose their doctor from among the participating physicians. The first of the county service bureaus in the Northwest was organized in Tacoma, Washington by Pierce County physicians in 1917. Numerous such bureaus were founded and many including the Pierce County bureaus are still in operation today as Blue Shield Plans.

In 1938, the American Medical Association's house of delegates endorsed the principle of voluntary health insurance, a move that encouraged physician cooperation in pre-payment programs. A year later, a Blue Shield Plan was begun in California as California Physicians Service. It provided physician services to employee group members of $1.70 per month and was limited to those earning less than $3,000 per year.

During the next few years, a number of similar Plans were established throughout the country. Although they were not affiliated, they had in common some elements that were to become basic to the Blue Shield movement.

The Blue Shield Plans were sometimes subsidized by physicians. They were founded around a nucleus of participation doctors who agreed to accept payment from the Plans as full payment for services rendered to subscribers. If the Plan ran out of money it would be the doctors who stood the losses. Most of the Plans worked closely with Blue Cross Plans for joint enrollment and fee collection.

The Blue Shield name and symbol were first used by a pre-paid plan in Buffalo, New York, known today as Blue Shield of Western New York. The name and symbol were informally adopted by the Associated Medical Care Plans in 1948, and registered officially in 1951 for Blue Shield Plans.

The need for a national organization was recognized early. Nine of the non-profit pre-payment plans joined together in 1946 to form Associated Medical Care Plans. Other Plans soon joined. Later, the organization became the National Association of Blue Shield Plans and eventually in 1976 the Blue Shield Association.

The two national organizations, consolidated staffs in 1978, and formally merged in 1982 to form the Blue Cross and Blue Shield Association.

Growth of Pre-payment

The health insurance concept was stimulated by the Depression, when millions of Americans found it difficult to meet day-to-day expenses, let alone the costs of an illness or accident. With the introduction of legislation like the 1935 Social Security Act, unemployment compensation, and old age assistance programs, the concept was given additional emphasis. With the onset of World War II, the fringe benefits concept began to develop and take hold within the United States. Employers, unable to raise wages because of the wage freeze laws, began to offer employees fringe benefits in lieu of wage increases. Because of the basic need which health insurance filled for Americans of all economic levels, health coverage was a much sought-after benefit.

The health insurance concept was further stimulated by the experience of returning servicemen. Accustomed to having their medical needs provided by the military, veterans heartily endorsed the pre-payment idea for themselves and their dependents. As American industry began to convert from a wartime economy to peacetime production, unions assumed strong positions in their negotiations for employee benefits. Employer tax exemptions for health and welfare contributions

further enhanced the movement. A favorable climate for union fringe benefit demands was thus created. As a final measure, when the U. S. Supreme court late in 1949 ruled that as part of the Taft-Hartley Act, employers had to bargain on welfare issues, the pre-payment concept caught on throughout the nation, sweeping every aspect of American industry. The Blue Cross and Blue Shield Plans grew rapidly.

Emergence of Competition

Up until now, the commercial insurance companies ahead been largely indifferent to the potential of health insurance. Seeing that it worked, the commercial companies were quick to include health insurance in their insurance packages offered to large groups. By 1963, more than 900 insurance companies were actively writhing health insurance.

The impact of the commercial insurers' practices was to significantly change the environment in which the Blue Cross and Blue Shield Plans operated. In the early years, for example, the Plans followed the practice of "community rating," meaning that the risk was spread over the entire subscriber population. The Plans offered everyone in the community the same benefits at the same price, regardless of their age, health status or employment. The commercial insurance companies entered the market with a different system known as "experience rating," which in its simplest form means that rates are based upon the amount of services the group uses and the risk represented by that particular group. The effect of this change was that the commercial insures could offer lower rates to groups with younger and healthier employees. The Blue Cross and Blue Shield Plans were forced to modify their practices by adopting experience rating in order to compete.

The Plans did not abandon the smaller groups and individuals who constitute higher risks, however. They still cover individuals and small groups whom the commercials avoid. They do not cancel coverage because of high use or poor health.
The Plans differ from commercial insurers also in their strong hospital and physician relations; they contract with hospitals and physicians to provide services, and they pay contracting providers directly, whereas the commercial companies simply pay the policy-holder a stated number of dollars. The Plans return a greater percentage of premium payments to subscribers in the form of benefits. Governed by boards of directors consisting of a majority of public representatives, they have a strong obligation to their communities and their subscribers which the commercial companies do not necessarily share.

The Changing Environment

Costs of hospital and medical care increased steadily and rapidly, especially after the advent of Medicare and Medicaid in 1966. Spurred by the economy, inflation, the infusion of money through government programs, the development of new technology, and the availability of insurance to cover medical advances, costs increased each year, sometimes as much as 15% per year. Cost containment became of paramount importance. The Blue Cross and Blue Shield Plans led the way in cost containment efforts, being first to support area-wide planning, for example, and encouraging the shift from in-patient to out-patient care.

Another example is the Medical Necessity Program to define and apply good standards of practice to the utilization of services. The Plans were in the lead in the development of "managed care'" including utilization review, second opinion and pre-admission certification programs. They developed new ways of paying hospitals. They developed health maintenance organizations and, more recently, preferred provider arrangements.

The early 1980's witnessed a revolution in the way health care is delivered and financed in the United States. Old partnerships and relationships evaporated as competition became the order of the day. For-profit hospital chains emerged, as did a wide variety of ambulatory care facilities, both hospital-affiliated and freestanding. Both providers and insurers began developing health maintenance organizations and preferred provider organizations. Hybrids of there are beginning to appear. Pressure from cutbacks in Medicare and Medicaid have forced providers to seek other sources of income at a time when they cannot turn to privately insured patients to make up the difference. Even non-profit hospitals are establishing multi-hospital systems in order to compete, and hospital corporations are getting into insurance. The trend among large employers has been toward self-insurance, and this has created a variety of administrative service arrangements.

While all these competitive pressures and complex relationships have changed the structure of the organization and the way the Plans operate, they have not changed the basic philosophy of the Blue Cross and Blue Shield Plans, that of serving the community by providing payment for quality, affordable health care coverage on a non-profit basis.

Move Toward National Unity: The Blue Cross Association

1937 -- The American Hospital Association established the Commission on Hospital Service -- a forerunner of both the Blue Cross Commission and the Blue Cross Association. The Commission, located in Chicago, provided information and advice for developing non-profit, voluntary health plans, served as a clearinghouse for ideas; and studied hospital and pre-payment plan financing.

1939 -- The Blue Cross symbol -- designed by E. A. van Steenwyk, President of the St. Paul, Minnesota Plan -- officially was adopted by AHA as the national emblem for the Plans which met AHA guidelines.

1941 -- The AHA dissolved the Commission on Hospital Service and replaced it with the Hospital Services Plan Commission (HSPC). The HSPC was financed with dues from the Plans rather than through AHA, and it took on responsibilities for research and Plan coordination.

1946 -- The Blue Cross Commission was created by AHA to replace HSPC. The Commission, also financed by Plan dues, help formulate and establish national Plan policies, as directed by the Plans at their annual meetings.

1948 -- The AHA incorporated the Blue Cross Association in Chicago to begin a subsidiary organization called Health Service, Inc. (HSI).
Through voluntary contributions by the Plans, HSI was organized as a Plan-owned insurance company to write uniform national health contracts.

1949 -- The Inter-Plan Service Benefit Bank was created as a clearinghouse to serve Blue Cross members who happened to be hospitalized or receive health care outside their local Plan areas, and the Blue Cross Commission in chicago took overs its administration.

1951 -- The Inter-Plan Transfer Agreement, which provides for transfer of membership between Plans without loss of benefit continuity, became operative and was administered by the Blue Cross Commission in Chicago.

1956 -- The Blue Cross Association was thoroughly reorganized and set up in New York City with responsibilities for national enrollment, advertising and federal government relations. It also assumed responsibility for administering the federal Military Dependents Coverage program, known as CHAMPUS.

1957 -- The Blue Cross Association established Inter-Plan private telecommunications wire service to streamline Inter-Plan claims and transfer communications. At this point, the Inter-Plan Bank and Inter-Plan Transfer administrative work was transferred from the Blue Cross Commission to the Association in New York.

1960 -- The Blue Cross Association assumed administrative and coordinating duties for the Federal Employee Health Benefits Program (FEP).

1962 -- The AHA dissolved the Blue Cross Commission, and the Blue Cross Association moved out of its subsidiary role and into a partnership role with AHA. This charge created a single, strong national association to represent the Plans, rather than two weaker national organizations in New York and Chicago. Under the new organization, the Blue Cross Association was directed by a twenty-five member Board of Governors consisting of 11 District Governors and 11 Members-at-Large, elected by the Plans, and three AHA Governors, nominated by AHA.

1962 -- Walter J. McNerney became the President of the Blue Cross Association, succeeding James E. Stuart.

1964 -- The Blue Cross Association established a Washington office and hired a Washington representative in anticipation of increased government interest in health pre-payment.

1965 -- The National Labor Office was begun in Washington by the Blue Cross Association to improve liaison between Blue Cross and national labor union leaders.

1966 -- Blue Cross contracted with the federal government as principal Medicare intermediary for hospital and other institutional stays by the elderly. The Blue Cross telecommunications system at Association headquarters in Chicago began handling all claims communication between the Plans and the Social Security record center in Baltimore.

1972 -- Formal ties with the American Hospital Association were severed. The name, trademark and Plan approval program were transferred from AHA to Blue Cross Association. A new stylized blue cross symbol was introduced.

History of the Blue Shield Association

1946 -- Nine Blue Shield Plans formed the Associated Medical Care Plans, forerunner of the National Association of Blue Shield Plans. The nine Plans were located in California; DesMoines, Iowa; Detroit, Michigan; Kansas City, Missouri; Omaha, Nebraska; Newark, New Jersey; Columbus, Ohio; Portland Oregon; and Camp Hill Pennsylvania.

1946 -- Frank E. Smith was named director, and served until 1954.

1947 -- During the first year of operation, the number of affiliated Plans jumped from the original nine to 45 Blue Shield Plans. Subscriber enrollment tripled to nearly 6 million.

1948 -- Blue Shield symbol was adopted by the Association and Plans.

1950 -- By 1950, there were 72 Blue Shield Plans with over 19 million enrolled.

1950 -- The blue shield symbol was officially adopted as reflected in the change of the name to Blue Shield Medical Care Plans, later (1960) to National Association of Blue Shield Plans, and (in 1976) to Blue Shield Association.

1950 -- A national service agency was established as a subsidiary of the Association, originally called Blue Shield Service,Inc., later changed to Medical Indemnity of America (MIA). The new organization functioned as a working arm of the Blue Shield system in writing coverage for national account groups under certain circumstances. MIA was able to underwrite gaps in coverage in national accounts caused by lack of uniformity among Plans created by different state laws and regulations.

1955 -- John W. Castellucci was named Executive Director (later named President). He served until 1971.

1971 -- Ned Parish served as President from 1971 to 1976.

1976 -- William E. Ryan served as President from 1976 until BSA's consolidation with Blue Cross Association in 1978.

National Merger

1978 -- The staffs of Blue Cross Association and Blue Shield Association were consolidated under one president, though each association retained its own board. Walter J. McNerney became President and William E. Ryan, Senior Executive Vice-President of both organizations.

1980 -- The associations moved to 676 N. St. Clair Street, Chicago.

1981 -- Bernard R. Tresnowski was appointed President, succeeding Walter J. McNerney.

1982 -- Blue Cross Association and Blue Shield Association were merged into one corporation with one board effective 7/1/82.

1982 -- HSI and MIA merged to become BCS Financial Corporation, the parent corporation for the BCS Insurance Company.

THE FLORIDA STORY

In 1944, as public demand grew for adequate hospital care like that offered to members of the armed services, the Florida Health Services Corporation opened a four-person office in Jacksonville to offer groups a pre-payment hospital care plan. In 1946, the Florida Medical Services Corporation introduced a group plan to cover doctor bills. By 1951, they had adopted the Blue Cross and Blue Shield names, respectively, and were offering the public non-group enrollment statewide.

The two organizations began administering various government programs in the mid-1950's, and in 1966 became the primary administrator of the new Medicare program in Florida. Florida's Blue Cross and Blue Shield Plans consolidated in 1980, enabling them to operate more efficiently while developing innovations like health maintenance organizations, preferred provider organizations and cost containment programs.

ACCOUNTABLE TO THE PUBLIC

In 1982, the organization became a mutual insurance company, which gave it greater financial flexibility to compete and operate more efficiently, and to fund innovative programs to benefit the public. Also, policyholders gained voting rights in the corporation.

Fifteen to 21 policyholders form the company's board of directors. A majority of them are from non-health care fields -- law, business, banking, education, economics -- to ensure that the organization is publicly accountable.

FLORIDA'S RECOGNIZED LEADER

Blue Cross and Blue Shield of Florida is the largest provider of health care insurance in the state. Employing approximately 5,000 people, we serve more than three million Floridians in some capacity. We hold the position as the state's leading health insurer because of a long-standing commitment: offer the highest quality health care products and the lowest possible price. Dedicated to that purpose, our employees work hard to provide superior customer service and meet the complex and changing needs of the people who count on us.

WORKING FOR EVERYONE

Blue Cross and Blue Shield of Florida is doing more than any other health insurer in the state to help control rising health care costs. Our expertise in the economics of health care delivery is widely recognized by government, industry and the public, as shown by our involvement with the Governor's Hospital Cost Containment Board.

Our company does more than just collect premiums and pay claims. We work with doctors, hospitals, employers and government agencies to keep costs down, and it helps all Floridians, not just our subscribers.

We're a household name, partly because of our strong community ties. For more than 50 years, we've developed our products around the special needs of the communities they were meant to serve. We know our neighbors.

MEETING THE CHALLENGE

With profound concern for serving people's health needs, Blue Cross and Blue Shield of Florida has the most innovative products and cost control programs in the state which include the largest PPO (Preferred Provider Organization) network in the state and the Health Maintenance Organization (HMO). No other insurer can match our accomplishments in scope or measurable effectiveness.

SOME OF WHAT WE OFFER

Blue Cross and Blue Shield of Florida offers individual and group health insurance products, as does its HMO network, which also provides financing. The corporation offers life insurance and related products.

COMPLEMENTARY COVERAGE

Often called a Medicare supplement, this serves Floridians age 65 or older who are covered by Medicare but need additional coverage it doesn't provide.

DIMENSION II

This comprehensive, major medical program helps persons under 65 pay for hospital and doctor bills and other needs such as ambulance service. Our policyholders share the costs through deductibles and co-insurance up to a maximum out-of-pocket amount.

PREFERRED PATIENT CARE

People who take advantage of Preferred Patient Care, our Preferred Provider Organization networks, share medical costs through deductibles and co-insurance, but they receive higher comprehensive benefits than if they use non-participating physicians and hospitals.

TEMPORARY PROTECTION

We offer a comprehensive major medical policy for folks who don't need permanent insurance, such as people who are between jobs. Because it's designed primary to cover accidents and emergency illness, premiums are about half the cost of permanent coverage.

CONTINUED PROTECTION PRODUCT

Regardless of their health, anyone who leaves group protection may switch to this product without having to satisfy another pre-existing health condition period.

NEW RESIDENT PRODUCT

We offer the same service, described in the preceding paragraph, to new Florida residents who were covered by another Blue Cross and Blue Shield plan.

GROUP PRODUCTS

TRADITIONAL INSURANCE

This lets employees choose their own providers, and it covers hospital and doctor bills and supplemental charges. Covered medical or hospital expenses usually are subject to a deductible and co-insurance up to a maximum amount. Benefits depend upon group size and subscriber needs. Some of the distinctive product variations are Business Employers Trust (BET), for two to nine employees, and Traditional Plus, which has several cost containment features for groups of 10 or more employees.

PREFERRED PROVIDER ORGANIZATION (PPO)

With our PPC, Preferred Patient Care, subscribers may choose any hospital or physician, but they receive greater benefits if they select providers contracting with PPC. Point of Service is PPO product that gives employees freedom of choice in selecting providers, with increased benefit coverage if they choose PPC physicians and hospitals, and standard traditional coverage if a non-PPC provider is chosen.

HEALTH MAINTENANCE ORGANIZATION (HMO)

HEALTH OPTIONS, INC., provides comprehensive health care services in exchange for a fixed, prepaid fee. Members have access to thousands of quality physicians, and some of Florida's most respected hospitals participate. HEALTH OPTIONS offices are located in major metropolitan areas -- members choose a local primary care physician who provides or approves their health care. In emergencies, they can receive are anywhere in the world, 24 hours a day.

LIFE INSURANCE

We offer life, accident and disability insurance through our subsidiary, Florida Combined Life Insurance Company, Inc.

DENTAL ASSISTANCE PROGRAM

Our dental coverage emphasizes preventive services and encourages families to visit their dentist regularly. The program is designed to pay 100 percent of preventive services, 80 percent of other services after a deductible is satisfied, and no less than 50 percent of non-preventive covered services.

ORGANIZATIONAL RESPONSIBILITIES

PRESIDENT:

The President is responsible for the conduct of the Plan within the policy guidelines set by the Board of Directors. In addition to the operation, the President is also chief spokesman and accountable for the implementation of corporate objectives and specific results within each of those objectives.

EXECUTIVE STAFF:

Composed of the President and those persons reporting directly to him, the Executive Staff is responsible for Strategic Planning and Management, leading and coaching subordinates, and supporting and strengthening relationships among groups and individuals.

GOVERNMENT PROGRAM OPERATIONS:

The Government Programs Operations Group is responsible for processing government program claims, servicing beneficiaries and providers; and exploring business opportunities.

PRIVATE BUSINESS OPERATIONS:

The Private Business Operations Group is responsible for providing Superior Customer Service in processing Blue Cross and Blue Shield claims, customer inquiries, and membership and billing documents in accordance with contracts.

HEALTH MAINTENANCE ORGANIZATION:

The Health Maintenance Organization is responsible for marketing and delivering access to quality care at reasonable prices to Floridians who want and need this form of health care alternative.

MARKETING AND FINANCE:

The Corporate Marketing and Finance Group is responsible for providing health and life insurance products and related services to meet the needs of the Florida marketplace at reasonable cost while ensuring the long-term financial effectiveness of the corporation.

HEALTH INDUSTRY SERVICES:

The Health Industry Services Group is responsible for developing and maintaining programs that contain health care costs; designing and implementing medical reimbursement policies; maintaining effective provider, professional, political and public relationships; increasing the volume of automated ("paperless") claims; and designing and implementing efficient, innovative, alternative delivery systems, such as PPO's and Managed Care programs.

HUMAN RESOURCES:

The Human Resource Division is responsible for helping management acquire, deploy, develop and maintain employees with the competencies and commitment needed to meet the challenges facing the corporation in a stimulating, innovative and creative work environment.

SPECIAL PROGRAMS:

The Special Programs Division is responsible for recommending innovative and creative approaches to all aspects of Superior Customer Service throughout the corporation, and for auditing the procedures and controls of the organization.

CORPORATE OBJECTIVES

1. **CUSTOMER/PUBLIC SERVICE, SATISFACTION AND SUPPORT** - Develop and maintain customer, public and governmental satisfaction and support by providing superior service.

2. **FINANCIAL EFFECTIVENESS** - Operate a financially strong organization through efficiency of operations with adequate reserves for contingencies and business development.

3. **MARKET** - Achieve an optimum share of the Florida private and government health care coverage markets in terms of benefit levels and population covered or served.

4. **NATIONAL SYSTEM** - Support achievement of our Corporate Objectives and the broader needs of society for high quality health care, at reasonable cost, by participating and cooperating effectively with the National Association and other Plans.

5. **OPERATIONAL AND ORGANIZATIONAL EFFECTIVENESS** - Develop and maintain an effective and progressive organization that will achieve the Corporation's planned business results, by attracting, developing and retaining high quality employees, maintaining a sound organizational structure, applying sound management processes and practices, and providing necessary physical resources and systems.

6. **PROVIDER/PROFESSIONAL - SERVICE AND SUPPORT** - Obtain the acceptance and participation of providers and professionals in the financing and delivery of quality health care to our members at a reasonable cost for sustainable competitive advantage.

7. **PUBLIC AND GOVERNMENT UNDERSTANDING AND ACCEPTANCE** - Gain public and governmental understanding, acceptance and support of corporate policies, programs and actions.

We will accomplish our Corporate Objectives by observing the following:

CORPORATE VALUES

- Respect for the Customer

  We will develop and market products and services that are responsive, adaptive and flexible in meeting our varied customer needs and wants in a timely, leadership fashion. We will provide superior customer service as our ultimate goal in all dealings with our subscribers and beneficiaries.

- Respect for the Individual

  We will treat all people as individuals, with the respect, dignity, and consideration due them as members of a free society. We will build and maintain a stimulative, innovative and creative work environment that will encourage and reward individual and team achievement. We will provide opportunities for advancement and a high sense of personal commitment and satisfaction for all employees.

- Pride in Excellence

  We will strive for excellence in the quality of work we perform and the quality of products and services we offer. Excellence is found in caring, in trying, in doing. It is the standard against which all our efforts will be measure.

EXECUTIVE STAFF - BIOGRAPHIES

William E. Flaherty is the ***President and Chief Executive Officer.*** Prior to joining the Florida Plan in 1979 as president and chief executive officer, Mr. Flaherty was president and chief executive officer of Blue Cross and Blue Shield of Delaware. He was executive vice-president of Blue Cross and Blue Shield of Michigan from 1972 through 1975.

Mr. Flaherty is an advocate of competition among health care providers as an alternative to the regulation of health care by government. Under his leadership, the company employs a strategy that recognizes managed care programs as the most effective means of controlling health care costs.

Mr. Flaherty's philosophy is to keep Blue Cross and Blue Shield of Florida competitive in all markets it serves through effective management of medical costs and effective program administration. As part of this philosophy, Mr. Flaherty is active on various boards, organizations and task forces on the local, state and national levels.

He serves as a member of the Board of Directors and Executive Committee of the Blue Cross and Blue Shield Association and its Nominating and Strategic Planning Committees. He also serves on the Managed Health Care Council and the Board of Health Plans Capital Service Corporation.

At the state level, he serves on the Governor's Task Force on Private Health Care Responsibility and recently as a member of the Governor's Committee on Workforce 2000 and its Education Subcommittee.

He is also past director of Florida's Hospital Cost Containment Board; the Governing Board of Health Systems Agency (Area 3); member of the Governor's Task Force on Competition and Consumer Choices in Health Care; the State Health Policy Task Force; and the Management Advisory Council for Health Rehabilitative Services (HRS).

Flaherty is a member of the Florida Council of 100; a member of the Board of the National Conference of Christians and Jews, Jacksonville Chapter; and a member of the University of North Florida's Foundation Board.

A graduate of Wayne State University in Detroit, MI, Flaherty also did graduate work in economics.

Michael Cascone, Jr., is ***Executive Vice-President, Private Business Operations.*** Mr. Cascone is an advocate of a quality work environment and team approaches to decision making and problem solving. At Blue Cross and Blue Shield of Florida, he is responsible for Legal Affairs, Government Relations, Information Systems and Private Business Operations.

He was instrumental in Blue Cross and Blue Shield of Florida's realignment by customer group, which positions the company to best meet the service needs of its customers. Mr. Cascone earned a bachelor of arts degree in mathematics from Jacksonville University. In 1985, he completed the Harvard Business School Advanced Management Program.

Kenneth C. Otis, II is *Executive Vice-President, Marketing and Health Care Services.* Mr. Otis played a key role in the revitalization of Blue Cross and Blue Shield of Florida's health maintenance organization, Health Options, and its integration with the company's other businesses. Health Options provides a product line that gives customers a wide variety of choices with an array of cost containment features.

Before coming to Blue Cross and Blue Shield of Florida, Mr. Otis was executive vice-president of Colonial Penn Group in Philadelphia where he was responsible for Colonial Penn's life, health and financial service companies.

Mr. Otis is a graduate of Yale with a MBS from the Harvard Graduate School of Business. He is chairman of the Hospital Cost Containment Board and Tax Watch.

Thomas E. Albright is *Senior Vice-President and Chief Marketing Executive.* Mr. Albright joined Blue Cross and Blue Shield of Florida in August, 1987 as vice-president of Health Industry Services, Field Operations. In December, 1987, he was promoted to senior vice-president of HIS. In November, 1988, he assumed marketing responsibilities chief marketing executive.

Before moving to Florida,Mr. Albright served as vice-president of Prudential Insurance Company in Minneapolis, NM, and was responsible for regional group operations. He also serves as senior vice-president of PruCare, Prudential's HMO subsidiary. Mr. Albright is a graduate of Villanova University.

Antonio J. Favino is *Senior Vice-President, Government Program Operations.* Mr. Favino has worked for Blue Cross and Blue Shield Plans in New York and Florida since 1955.

Prior to joining Blue Cross and Blue Shield of Florida in 1979, he was assistant vice-president for Beneficiary and Provider Services, and assistant vice-president for Part A and B Medicare Operations for Blue Cross and Blue Shield of Greater New York. From 1955 to 1974, Mr. Favino served as vice-president of Regular Business Operations, vice-president for Government Programs for Blue Shield of Greater New York.

At the Florida Plan, he served as director of government Programs and as director of Medicare Part A Claims until he was appointed as vice-president of Medicare Part A in March, 1983. Mr. Favino received a bachelor of arts degree from New York University.

Richard L. Thomas is *Senior Vice-President of Finance and Treasurer.* Mr. Thomas joined the Florida Plan in May, 1988 as vice-president of Finance and Planning. In October, 1989, he was named senior vice-president of Finance and Treasurer.

Before coming to Blue Cross and Blue Shield of Florida, Mr. Thomas served as senior vice-president and chief financial officer with Bank Western in Denver, CO. Prior to that, he held various positions with Central Bancorporation, also in Denver, including chief financial officer, executive vice-president and chief operations officer.

Thomas is a certified public accountant and also worked in public accounting with Peat, Marwick, Main. He earned a bachelor of science degree in business administration and accounting from Kansas State University and a MBA degree in business administration from the University of Iowa.

Thomas is a member of the Financial Executive Institute, American Institute of Certified Public Accountants, and Colorado Society of Certified Public Accountants.

Bruce A. Davidson is *Vice-President, General Counsel and Corporate Secretary.* Since October, 1988, Mr. Davidson has served as vice-president, General Counsel and Corporate Secretary of the Florida Plan.

Before joining Blue Cross and Blue Shield of Florida, Mr. Davidson worked for Sentry Insurance Group in Stevens Point, WS, for 10 years. The various titles and positions he held include vice-president and general counsel, division vice-president responsible for a five-state operation, and vice-president of claims.

Mr. Davidson graduated from Occidental College in Los Angeles, CA, with a bachelor of arts degree in political science and history. He obtained his juris Doctor degree-with-distinction-from Duke University Law School.

Michael R. Johnson is *Vice-President Human Resources.* Michael R. Johnson came to Blue Cross and Blue Shield of Florida in February, 1990. In July, 1990, he was appointed vice-president of Human Resources.

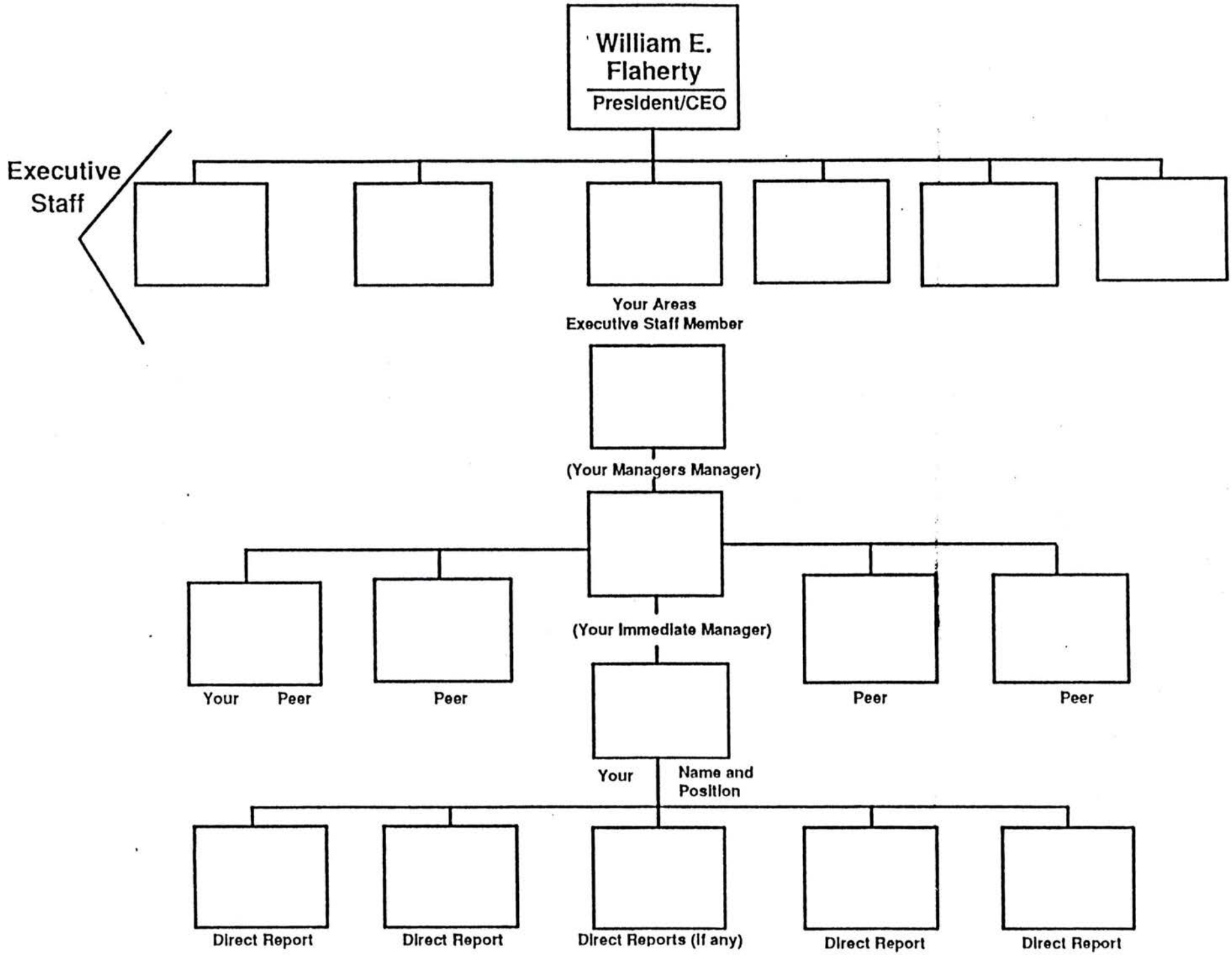
Prior to joining Blue Cross and Blue Shield of Florida, he held the position of vice-president, Human Resources, for First Data Resources, which is a subsidiary of American Express. His other previous professional experience includes positions and Xerox Corporation and Wang Labs, Inc. Mr. Johnson received his bachelor of science in mathematics and also a master of arts degree in mathematics/education from the University of Missouri in Kansas City.

EXECUTIVE & SENIOR STAFF LISTING
AS OF APRIL, 1991

NAME	TITLE
FLAHERTY, William E.	President
ROGERS, Jan	Administrative Assistant
ALBRIGHT, Thomas E.	Sr. V.P. & Chief Marketing Executive
Glover, Evelyn	Executive Secretary
BRODSKY, Ernest N.	V.P., Product Management
Batts, Vickie	Executive Secretary
BURCHETT, Peter	Regional V.P., Central Region
Cardona, Maureen	Executive Secretary
CASCONE, Michael Jr.	Executive V.P., PBO Operations
Killebrew, Joan	Executive Secretary
CASSADY, George E.	V.P., Org. Development Consulting (PBO)
Wood, Maxine	Executive Secretary
DAVIDSON, Bruce	V.P., General Counsel & Corporate Secretary
Hodges, Terrie	Executive Secretary
DAVIS, Stephen C.	V.P., Corporate Project Development
Blaylock, Marilyn	Executive Secretary
DEMERY, Carl J.	V.P., Financial Planning & Perf. Reporting
Thomas, Patty	Executive Secretary
DINGFIELD, Dave	V.P., Information Systems and Operations
Wood, Sherry	Executive Secretary
DICENZA, Judith A.	V.P. & Actuary, Actuarial & Underwriting
Carter, Faye	Executive Secretary
DOWNS, Harry E.	V.P. Information Systems
Teter, Nancy	Executive Secretary
DUNN, Tom	V.P., National/Corporate Accounts Operations
Hirst, Patty	Executive Secretary
FAHNER, Hal	V.P., Corporate Marketing
Helms, Eleanor	Executive Secretary

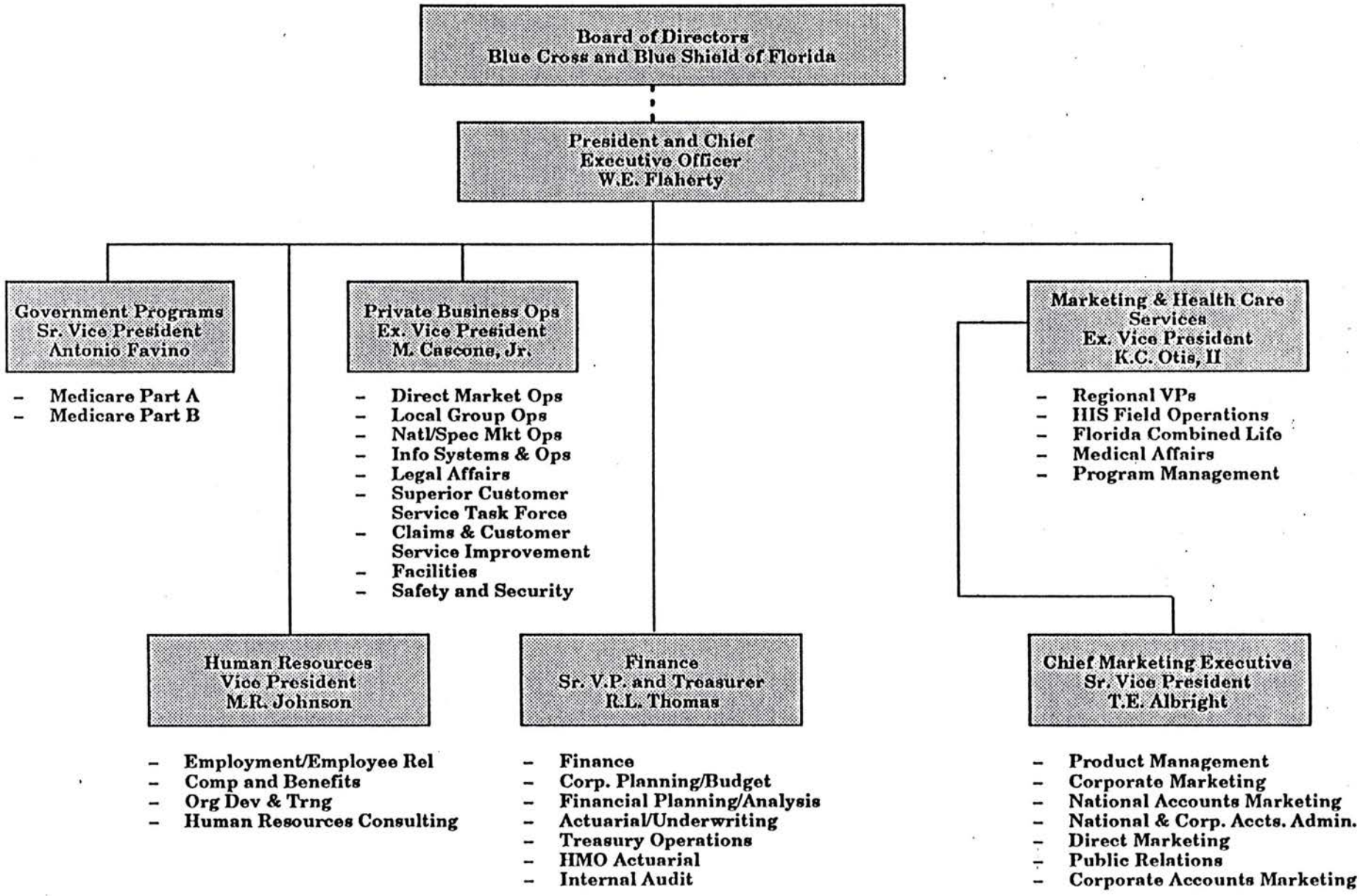
NAME	TITLE
FAVINO, Antonio J.	Sr. V.P., Governnment Program Operations
Bloom, Claudia	Executive Secretary
FUENTES, Fabian B.	V.P., National Accounts Marketing
Purvis, Darlene	Executive Secretary
GRANTHAM, L. Joseph	V.P., Corporate Project Development
McMillan, Debbie	Executive Secretary
HIGHTOWER, Michael R.	V.P., Governmental & Legislative Relations
Steckley, Linda	Executive Secretary
HOUSH, Skip	Regional V.P., Northwest Region
Hiers, Cathy	Executive Secretary
HUBBARD, Tony A.	V.P., Corporate Medical Policy
Evans, Kacy	Executive Secretary
JENNINGS, Paul	V.P., Direct Marketing
Stubbs, Judith	Executive Secretary
JOHNSON, Michael R.	V.P., Human Resources Division
Smith, Sybil	Executive Secretary
LIPTAK, Walter	V.P., Life Company Operations & President, Florida Combined Life
Seefried, Dawn	Executive Secretary
LUFRANO, Robert I.	V.P., Medical Affairs
Luman, Phyllis R.	Executive Secretary
MENHEIM, Dudley	Regional V.P., West Coast Region
Gray, Kimberly	Executive Secretary
OTIS II, Kenneth C.	Executive V.P., Marketing & Health Care Service
Fauth, Jill	Executive Secretary
Payne, Larry L.	V.P., Local Group Market Operations
Rhoden, Joan	Executive Secretary
PIES, Harvey E.	V.P., Special Counsel for Managed Care Systems
Shirah, Gwen	Executive Secretary

NAME	TITLE
PRALLE, Robert F. Tirado, Daphne	V.P., Corporate Accounts Executive Secretary
REED, William H. Open	V.P., Corporate Accounts Marketing Executive Secretary
RICHARDS, Charles R. Felker, Debbie	V.P., Finance Executive Secretary
SCOTT, W. Charles Cole, Sharon	V.P., Medicare Part B Operations Executive Secretary
SEBOK, Robert S. Parker, Amy	V.P., Group Sales Executive Secretary
SELLERS, Kenneth G. Brannen, Laura	Regional V.P., Northeast Region Executive Secretary
SMITH, Richard (Dick) Reddy, Alicia	Regional V.P., Southern Region Executive Secretary
STANLEY JR., Thomas W. Witt, Vicki	V.P., Program Management Executive Secretary
THOMAS, Richard L. Herren, Cathy	Sr. V.P., Treasurer & Chief Financial Officer Executive Secretary
VAN DYKE, Donald J. Self, Janice	V.P., Direct Market Operations Executive Secretary
WASHINGTON, Al G. Alford, Paige	V.P., Organizational Development Consulting Executive Secretary
WILLIAMS, Patricia A. Paxton, Pat	V.P., Medicare Part A. Executive Secretary



This organizational Chart is for your use only, and is designed to help you begin to establish relationships in your

BLUE CROSS AND BLUE SHIELD OF FLORIDA
ORGANIZATIONAL CHART



ORGANIZATION CHART

At BCBSF, we highly value development of relationships with peers, management and throughout the organization.

To build these relationships, you need to know who your peers and managers are. Now that you've seen the corporate organizational chart, we're going to ask you to give a try at developing one more specific for your work unit.

Attached is a blank Organizational Chart with a sample chart and the corporate organizational chart. Between now and Friday, we would like for you to work with a peer or perhaps your manager or supervisor and try to complete the chart. It may not be easy, but give it your best shot. You will be voluntarily reviewing a couple of them at the group presentation Friday.

What we are looking for is:

- Who is the President and CEO?
- Who is the Executive Staff member associated with your unit?
- What other officers are associated with your unit?
- Who are your immediate director(s) and managers(s)?
- Who are your peers, and what are their jobs?
- Who are your direct reports, if any?

Any of this information you can find out would be helpful to your transition into the work area.

If you have any questions during the week, call Susan Porter at 791-6832.